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9 **BEFORE THE**
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

12 **TINA RENEE WRIGHT**
13 400 Poplar Grove Place
14 Summerville, SC 29483

15 Registered Nurse License No. 618117

16 Respondent.

Case No. **2009-317**

OAH No.

A C C U S A T I O N

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18 Complainant alleges:

19 **PARTIES**

20 1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her
21 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
22 Consumer Affairs.

23 2. On or about May 5, 2003, the Board of Registered Nursing issued Registered Nurse
24 License Number 618117 to Tina Renee Wright (Respondent). The Registered Nurse license was
25 in full force and effect at all times mentioned in the Accusation and will expire on April 30, 2011,
26 unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

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REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1443, states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

8. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

1 (2) Formulates a care plan, in collaboration with the client, which ensures
2 that direct and indirect nursing care services provide for the client's safety,
3 comfort, hygiene, and protection, and for disease prevention and restorative
4 measures.

5 (3) Performs skills essential to the kind of nursing action to be taken,
6 explains the health treatment to the client and family and teaches the client and
7 family how to care for the client's health needs.

8 (4) Delegates tasks to subordinates based on the legal scopes of practice of
9 the subordinates and on the preparation and capability needed in the tasks to be
10 delegated, and effectively supervises nursing care being given by subordinates.

11 (5) Evaluates the effectiveness of the care plan through observation of the
12 client's physical condition and behavior, signs and symptoms of illness, and
13 reactions to treatment and through communication with the client and health team
14 members, and modifies the plan as needed.

15 (6) Acts as the client's advocate, as circumstances require, by initiating
16 action to improve health care or to change decisions or activities which are against
17 the interests or wishes of the client, and by giving the client the opportunity to
18 make informed decisions about health care before it is provided.

19 COST RECOVERY

20 9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
21 administrative law judge to direct a licensee found to have committed a violation or violations of
22 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
23 enforcement of the case.

24 STATEMENT OF FACTS

25 10. Patient D.D., a 61 year old African-American female, was admitted to the University
26 of California, San Diego (UCSD), Medical Center, Intensive Care Unit (ICU) from June 5, 2003
27 to July 4, 2003. Patient D.D. was admitted to the ICU with multiple medical problems. She had
28 a history of morbid obesity (325 pounds) with some disability. Patient D.D.'s medical records
indicate that patient D.D. had been sitting in a chair for two straight days prior to being admitted
to the hospital. Her medical records also note that patient D.D.'s skin was intact on admission to
the ICU.

11. On June 7, 2003, patient D.D. was placed in a Bariatric bed (adjustable bed for larger,
overweight patients).

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1 12. On June 8, 2003, in the Physician Progress Notes, patient D.D. was diagnosed with
2 Deep Vein Thrombosis.

3 13. On June 8, 2003, from 7:00 p.m. to June 9, 2003 at 7:00 a.m., Respondent took care
4 of patient D.D. while she was in the ICU.

5 14. On June 8 to 9, 2003, Respondent checked off in patient D.D.'s medical records, in
6 the "Equipment" section in "Shift Assessment," that patient D.D. had a "Special Bed" but
7 Respondent did not list the type of special bed.

8 15. On June 9, 2003, ankle blisters and lower extremity bullae (blisters) were noted in
9 the Physician Progress Notes for patient D.D. Later that day, patient D.D. underwent surgery for
10 incision and drainage of an abscess of the medial left leg, exploratory fasciotomies medial and
11 lateral left leg and aspiration of the ankle joint.

12 16. On June 11, 2003, the first documentation of a Stage 1 skin tear on patient D.D.'s
13 coccyx was noted on the skin diagram on the Nursing ICU flow sheet. Patient D.D. was assessed
14 as a low risk under the Braden Skin Risk Assessment scale for predicting pressure ulcer risk. An
15 Allevyn dressing was applied at that time.

16 17. On June 12, 2003, a skin tear on the right buttock was listed as a Stage 2 pressure
17 ulcer on the Nursing ICU flow sheet. That day, patient D.D. was assessed as a high risk using the
18 Braden Skin Risk Assessment scale.

19 18. On June 13, 2003, the Braden scale risk was documented as "moderate" and the skin
20 integrity sheet documented only "coccyx" with no stage or size.

21 19. On June 14, 2003, the Nursing ICU flow sheet reflected the wound on patient D.D.'s
22 right buttock "was healing" and it was classified as stage 2/1. There was an order to "apply skin
23 care under both breasts due to skin breakdown; turn every 2 hours PRN (as necessary) and avoid
24 pressure to coccyx and buttocks." There was no nursing documentation reflecting any skin
25 breakdown under the breasts.

26 20. On June 16, 2003, there was documentation on the Nursing ICU flow sheet that the
27 coccyx wound was open and it was staged as a 2 or 3.

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1 21. On June 18, 2003, it was documented on the Nursing ICU flow sheet that patient
2 D.D.'s coccyx skin was "torn off."

3 22. On June 22, 2003, there was day shift nursing documentation on the Nursing ICU
4 flow sheet, identifying multiple pressure ulcers 1) on the left buttock, 2) on the right buttocks and
5 3) on the right thigh.

6 23. On June 23, 2003, in the Physician Ortho Progress Note, there was a description of a
7 small superficial ulcer on patient D.D.'s heel.

8 24. On June 24, 2003, the day shift reported on the Nursing ICU flow sheet there were
9 Stage 3 pressure ulcers on patient D.D.'s left and right buttocks and the right thigh.

10 25. On June 26, 2003, in the Physician's Progress Notes, Internal Medicine charted "the
11 patient has a decub and skin breakdown under breast-wound care begun-will document/take
12 pics." The Internal Medicine Service Attending wrote a progress note stating "sore outside left
13 chest wall, sacrum and newly noted decub -will increase nursing care to decub."

14 26. On June 27, 2003, the Internal Medicine Service intern documented "several large
15 areas of decubs; low grade fever due to decubs??? Will stage when available to turn." On the
16 Infectious Disease progress note, it was charted "Pics of back decubs noted." There was an order
17 for a wound consultant and to photograph the wounds. On the Nursing ICU flow sheet, pressure
18 ulcers were documented on the buttocks as "large variety, stage 1&2, the left breast, and a left
19 heel pressure ulcer." Allevyn dressing was listed. A pressure reducing air mattress was ordered.

20 27. On June 28, 2003, the Medical Resident wrote "stage 2 decub sacrum bilaterally. Try
21 to dc (discontinue) rectal tube soon to keep decubs clean from diarrhea."

22 28. On June 29, 2003, the Internal Medicine intern documented "low grade fevers -source
23 due to decubs??? 3 large decubs, stage 2 gluteal, perianal area. Wound care, frequent shifting, air
24 mattress."

25 29. On July 3, 2003, the Internal Medicine Attending charted "continuous decub care;
26 airbed."

27 30. On July 4, 2003, patient D.D. was discharged to Evergreen Skilled Nursing facility.
28 The physician note discharged patient D.D. with one of her diagnoses as being decubitus ulcers.

1 Evergreen Skilled Nursing staff documented the following areas of skin breakdown on the day of
2 patient D.D.'s transfer to their facility from UCSD Medical Center:

- 3 1. Coccyx - 7 cm x 3.5cm
- 4 2. Left Ischium - 7cm x 5cm
- 5 3. Right Ischium - 10cm x 6cm
- 6 4. Right Ischium - 5cm x 2cm
- 7 5. Right Ischium - 2cm x 1.5cm
- 8 6. Left Heel - 5cm x 2.5cm
- 9 7. Right Heel - 7cm x 8cm
- 10 8. Left Lower Leg, medial aspect - 5cm x 4cm
- 11 9. Left Lower Leg, medial aspect - 2 cm x 2cm
- 12 10. Left Lower Leg, medial aspect - 1 cm x 1.5cm
- 13 11. Left Lower Leg, medial aspect - 1 cm x 1.5cm
- 14 12. Right Thigh - 1cm x 1cm
- 15 13. Right Thigh - 3cm x 1.5 cm
- 16 14. Right Thigh - 2cm x 1cm
- 17 15. Right thigh medial - 7cm x 2cm
- 18 16. Right groin - 1cm x 1cm
- 19 17. Right Breast - 10cm x 10 cm
- 20 18. Left Breast - 10 cm x 10cm
- 21 19. Right Upper Back - 7cm x .5cm

22 The above list of skin breakdown on patient D.D.'s admission to Evergreen Skilled Nursing
23 facility was much more detailed and extensive than what was charted at UCSD Medical Center.

24 FIRST CAUSE FOR DISCIPLINE

25 (Incompetence)

26 31. Respondent is subject to disciplinary action under section Code section 2761,
27 subdivision (a)(1), on the grounds of unprofessional conduct, in that on her shift from 7:00 p.m.
28

1 on June 8, 2003 to 7:00 a.m. on June 9, 2003, Respondent was incompetent in her care of patient
2 D.D. within the meaning of Regulation 1443, as follows:

3 32. Respondent displayed a lack of knowledge on the use and purpose of the Braden skin
4 Risk Scale when she failed to provide and document instructions for follow-up preventative care
5 and interventions for patient D.D. to avoid skin breakdown based on a Braden Skin Risk
6 Assessment score of 11 for patient D.D.

7 33. Respondent displayed a lack of training and lack of information concerning
8 assessment and identification defining the use of a specialty bed when she checked "Special Bed"
9 in the "Equipment" section under "Shift Assessment" in patient D.D.'s medical records.
10 Respondent failed to exhibit the knowledge to determine if patient D.D.'s bed was pressure
11 relieving. Respondent failed to demonstrate that she was familiar with the difference between a
12 "bariatric bed" and a "specialty bariatric bed." Patient D.D. did not have a specialty bed on
13 June 8, 2003 and did not receive a specialty bed until June 27, 2003.

14 SECOND CAUSE FOR DISCIPLINE

15 (Unprofessional Conduct)

16 34. Respondent is subject to disciplinary action under Code section 2761, subdivision (a),
17 on the grounds of unprofessional conduct, in that on her shift from 7:00 p.m. on June 8, 2003 to
18 7:00 a.m. on June 9, 2003, Respondent committed acts constituting negligence in her care of
19 patient D.D. as follows:

20 35. On the ICU flow sheet, under "Treatments/Procedures," in the "Activity" section,
21 Respondent failed to document turning or moving patient D.D. every two hours.

22 36. When Respondent charted in the "Shift Assessment" section under "Cardiovascular"
23 for "Edema" in patient D.D.'s medical records, Respondent marked "none." This section
24 included the extremity pulses. Respondent did not address, and ignored concerns in the progress
25 notes of the medical record from earlier that day, that documented that patient D.D. had problems
26 with cellulitis, induration, and blisters in her lower extremities. Respondent failed to formulate a
27 nursing diagnosis or plan of care regarding the potential for skin breakdown, or further skin
28 breakdown, on patient D.D.'s extremities.

1 37. Respondent failed to critically evaluate patient D.D.'s potential sites for skin
2 breakdown, possible infections and failed to develop care plans and preventative nursing
3 interventions for patient D.D. to prevent further skin breakdown. Respondent failed to document
4 in the "Problems/Interventions/Outcomes" area of the medical records for patient D.D. that
5 Respondent had performed any follow-up on the concerns from the previous shift. Respondent
6 failed to follow up and address on her shift the condition of patient D.D.'s left lower leg swelling,
7 blisters and Deep Vein Thrombosis. The previous shift documented lower left extremity
8 cellulitis and elevated patient D.D.'s left leg on a pillow. Respondent did not address the
9 condition of patient D.D.'s left lower extremity in her shift documentation notes.

10 38. Respondent failed to document contacting any physician about patient D.D.'s
11 elevated temperatures. During Respondent's shift, patient D.D.'s temperature was recorded at
12 11:00 p.m. as 101.5 F, at 6:00 a.m. as 101.5 F and at 7:00 a.m. as 101.3 F. Respondent failed to
13 critically evaluate patient D.D. for possible infections or conduct any follow up.

14 PRAYER

15 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
16 and that following the hearing, the Board of Registered Nursing issue a decision:

- 17 1. Revoking or suspending Registered Nurse Number 618117, issued to Tina Renee
18 Wright;
- 19 2. Ordering Tina Renee Wright to pay the Board of Registered Nursing the reasonable
20 costs of the investigation and enforcement of this case, pursuant to Business and Professions
21 Code section 125.3; and
- 22 3. Taking such other and further action as deemed necessary and proper.

23 DATED: 6/16/09

24 Ruth Ann Terry
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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